UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

BRIAN TINGLEY,

Plaintiff,

v.

ROBERT W. FERGUSON, in his official capacity as Attorney General for the State of Washington; **UMAIR A. SHAH**, in his official capacity as Secretary of Health for the State of Washington; and **KRISTIN PETERSON** in her official capacity as Assistant Secretary of the Health Systems Quality Assurance division of the Washington State Department of Health,

Defendants.

Case No. 3:21-cv-5359

EXPERT DECLARATION OF CHRISTOPHER ROSIK, PH.D. IN SUPPORT OF PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

I, Dr. Christopher Rosik, hereby declare as follows:

1. I hold a Ph.D. in clinical psychology from an APA-approved program at Fuller Graduate School of Psychology in Pasadena, California.

2. I have been a licensed clinical psychologist for over thirty years, and I currently practice at the Link Care Center in Fresno, California, where I am the Director of Research.

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3. I am a clinical faculty member of Fresno Pacific University, as well as a member of the American Psychological Association, International Society for the Study of Trauma and Dissociation, and the National Association of Social Workers.

4. A fuller review of my professional experience and publications is provided in my curriculum vitae, a copy of which is attached hereto as **Exhibit A**.

5. I have further identified the academic, scientific, and other materials referenced in this declaration in the references attached hereto as **Exhibit B**.

6. In this declaration, I provide my expert views, with reference to recent scientific publications, on three questions:

- Whether current science supports the belief that same-sex attraction is genetically determined? As I explain in Section I below, it does not, but rather contradicts that belief.
- Whether current science supports the belief that individuals who experience some same-sex attraction rarely experience any change in those attractions. As I explain in Section I below, it does not. Instead, many studies document that these individuals very often experience significant changes in their experienced sexual attractions.
- Whether current science supports the assertion that voluntary, conversational counseling to assist individuals who wish to achieve a reduction in same-sex attractions or an increase in opposite-sex attractions is harmful to most or even many participants. As I explain in Section II below, no methodologically sound study supports that conclusion, and some more careful recent studies find that such counseling is beneficial to mental health on average.

I. The available science indicates that same-sex attraction is not genetically determined and often changes.

7. It is often asserted that sexual attractions or orientation are fixed and not subject to change. In my opinion, this is incorrect, and indeed is unsustainable in the face of modern science.

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8. In fact, a much-cited recent review of the relevant scientific literature by prominent LGBTQ-advocate authors concluded that "[A]rguments based on the immutability of sexual orientation are unscientific, given that scientific research does not indicate that sexual orientation is uniformly biologically determined at birth or that patterns of same-sex and other-sex attractions remain fixed over the life course." (Diamond & Rosky, 2016, p.2). I agree with these authors.

9. Diamond and Rosky conclude that rather than resting on science, assertions that sexual orientation cannot change "rely on unspoken legal and moral premises whose validity must be questioned." (Diamond & Rosky, 2016, p.11).

A. Same-sex attraction is not genetically determined.

10. In the past, many authors have hypothesized that same-sex attractions are biologically determined. However, no such causes have been found. A 2019 large-scale study by a team of authors from Harvard, MIT, and several other prestigious institutions analyzed the genomes of *almost half a million individuals*, along with self-reported information about heterosexual and same-sex sexual behaviors from these individuals. This massive study found only "very small" correlations between any genes and same-sex behavior. The authors concluded that the impact of genetic factors on sexual orientation were so small that they "do not allow meaningful prediction of an individual's sexual preference." (Ganna et al., 2019. p.6).

11. Before the extensive genomic work of Ganna et al. published in 2019, some studies had attributed a somewhat higher influence of genetics on the formation of sexual orientation. But even these studies attributed only minority influence to genetics, leaving sexual orientation no more genetically determined than "a range of characteristics that are not widely considered immutable, such as being divorced, smoking, having lower back pain, and feeling body dissatisfaction." (Diamond & Rosky, 2016, p.4).

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12. Rather than being biologically predestined, many individuals who identify as other than heterosexual believe that they possessed and exercised choice in their sexual orientation. Surveying the literature again, Diamond and Rosky reject the claims of "[b]oth scientists and laypeople . . . that same-sex sexuality is rarely or never chosen," instead concluding that "individuals who perceive that they have some choice in their same-sex sexuality are more numerous than most people think." (Diamond & Rosky, 2016, p.20). In my own counseling experience, I have worked with patients who likewise perceive that they initially made choices that led to or strengthened their same-sex attractions.

13. Suggesting there is much left to learn about the complex origins of same-sex attractions and behavior, even the APA's own stance on the biological origin of sexual orientation has shifted over the years. In 1998, the APA appeared to support the theory that homosexuality is innate and people were simply "born that way," asserting that "There is considerable recent evidence to suggest that biology, including genetic or inborn hormonal factors, plays a significant role in a person's sexuality" (APA, 1998).

14. But just ten years later, in 2008, the APA described the matter differently:

> "There is no consensus among scientists about the exact reasons that an individual develops a heterosexual, bisexual, gay, or lesbian orientation. Although much research has examined the possible genetic, hormonal, developmental, social, and cultural influences on sexual orientation, no findings have emerged that permit scientists to conclude that sexual orientation is determined by any particular factor or factors. Many think that nature and nurture both play complex roles...." (APA, 2008; emphasis added).

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B. Same-sex attraction frequently changes.

15. It has often been assumed or asserted in the literature in the past, and is still often asserted by non-scientists or in the popular press today, that sexual orientation is fixed and unchanging.

16. In my opinion, based both on my own clinical experience and more recent scientific research, this assumption is not just unfounded, but provably false.

17. Writing in 2016, Diamond and Rosky concluded, after surveying the scientific literature, that "Studies unequivocally demonstrate that same-sex and other-sex attractions do change over time in some individuals," and that the evidence for this is now so clear as to be "indisputable." (Diamond & Rosky, 2016, p.6-7).

18. Empirically, the frequency of change in sexual orientation is particularly high among those who experience same-sex attraction.

19. Thus, after reviewing and summarizing extensive scientific literature, chapters in the American Psychological Association *Handbook of Sexuality and Psychology* conclude that "research on sexual minorities [i.e., all those who do not identify as exclusively heterosexual] has long documented that many recall having undergone notable shifts in their patterns of sexual attractions, behaviors, or identities over time" (636), and that "Youth who are unsure or uncertain of their identity predominantly transition to a heterosexual identity" (562).

20. Many individual articles and studies reach the same conclusion.

21. A study by authors from the Harvard School of Public Health and other respected institutions examined "gender- and age-related changes in sexual orientation identity from early adolescence through emerging adulthood" in over 13,000 youth from 12 to 25 years of age, examining data collected for each

participant at four times over a period of seven years. (Ott et al., 2011). On this sample, Diamond and Rosky note that "Of the 7.5% of men and 8.7% of women who chose a nonheterosexual descriptor at ages 18 to 21, 43% of the men and 46% of the women chose a different category by age 23. Among the same-sex-attracted youth who changed, 57% of the men's changes and 62% of the women's changes involved switching to completely heterosexual." (Diamond & Rosky, 2016, p.7-8).

22. Diamond and Rosky gather the results of the Ott et al. study along with two separate "longitudinal" studies (i.e., studying the same individuals over time), done by different researchers at different times on different samples, and report that, for young adult populations (starting ages from 18 to 26), of those who initially reported "any same sex attractions," every study found that between 40% to 60% of each sex reported a "change in attractions" when resurveyed a few years later. Of those who experienced a "change," at least half and as high as 83% "changed to heterosexuality at the second assessment." (Diamond & Rosky, 2016, p.7).

23. In another review of the literature, Diamond provided the following summary: "The other major conclusion that we can draw from these studies is that change in patterns of same-sex and other-sex attraction is a relatively common experience among sexual minorities. Across the subgroups represented [taken from several large datasets], between 25 and 75% of individuals reported substantial changes in their attractions over time, and these findings concord with the results of retrospective studies showing that gay, lesbian, and bisexual-identified individuals commonly recall having undergone previous shifts in their attractions. Such findings pose a powerful corrective to previous oversimplifications of sexual orientation as a fundamentally stable and rigidly categorical phenomenon." (Diamond, 2016, p.253).

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24. Authors analyzing data collected for approximately 2500 individuals as part of the National Survey of Midlife Development in the United States found that, of those of any age who identified at the start of the study as bisexual, a decade later approximately 32% identified as exclusively heterosexual, while of those who identified at the start of the study as homosexual (that is, exclusively attracted to the same sex), a decade later 28% identified as attracted to the opposite sex (heterosexual or bisexual). (Mock & Eibach, 2012, Table 2). Heterosexual identity was far more stable: among those who identified as heterosexual at the start of the study, only 0.78% of men and 1.36% of women identified a different orientation a decade later. (Mock & Eibach, 2012, p.645).

25. Another often-cited paper by prominent researchers summarized scholarship and cautioned that "there was little evidence of true bipolarity in sexual orientation" and that sexual orientation is instead "a continuous construct." These authors observed that one study found that "Only 38% of exclusive same-sex attracted females stayed in this group [between ages 21 and 26], with the rest moving into 'occasional' same-sex attraction (38%) or exclusive opposite-sex attraction (25%)," while another found that across a multi-year study period "Most (62%) of young women changed their identity labels at least once. . . Over time, lesbian and bisexual identities lost the most adherents and heterosexual and unlabeled identities gained the most." In short, this paper's literature review found that "Evidence to support sexual orientation stability among nonheterosexuals is surprisingly meager." (Savin-Williams & Ream, 2007, p.386).

26. Savin-Williams' and Ream's own study of adolescents and young adults pointed to the same conclusion, "highlight[ing] the high proportion of participants with same- and both-sex attraction and behavior that migrated into opposite-sex categories between [interview periods]." (Savin-Williams & Ream, 2007, p.388).

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27. Meanwhile, other noted scholars argue that the "sexual orientation" categories of "gay" or "straight" are to some extent socially defined, such that surrounding "cultural press" may in essence coerce an adolescent boy who merely experiences "affectional bonding" with another male to categorize and thus understand himself through the rigid binary category of "gay," whereas that same type of affection would not lead the boy to think of himself that way in a different cultural setting. (Hammack, 2005).

28. My observations in my own professional experience are consistent with the findings of the many studies cited above concerning the inconstancy of same-sex attraction or identification. Over the years I have provided counseling support for several individuals who came to me experiencing unwanted same-sex attractions and behaviors, some of whom over time came to reduce same-sex attractions and behaviors, increase opposite-sex attractions, and, in general, further develop their heterosexual potential.

II. There is no statistically valid evidence that voluntary counseling is harmful.

29. It is often asserted that "conversion therapy" or other forms of "sexual orientation change efforts" (or "SOCE") are severely harmful. In fact, there is no meaningful evidence that conversational counseling with willing clients to explore possibilities of change in unwanted same-sex attractions and behaviors is harmful to most or even many participants.

A. The conclusions of the 2009 task force of the American Psychological Association.

30. In a major 2009 report based on a review of many studies, a task force of the American Psychological Association concluded:

> "Although the recent studies do not provide valid causal evidence of the efficacy of SOCE or of its harm, some recent studies document that there are people who perceive that they have been harmed through SOCE… just as other recent studies document that there are people who perceive that they have benefited from it. . . . . We conclude that there is a dearth of scientifically sound research on the safety of SOCE. Early and recent research studies provide no clear indication of the prevalence of harmful outcomes among people who have undergone efforts to change their sexual orientation or the frequency of occurrence of harm because no study to date of adequate scientific rigor has been explicitly designed to do so. Thus, we cannot conclude how likely it is that harm will occur from SOCE." (42) b) "[I]t is still unclear which techniques or methods may or may not be harmful." (91)

31. This statement is twelve years old. However, writing in 2021 a group of proponents of "SOCE" bans affirmed that the pertinent research base remains sparse up to the present, providing an insufficient basis on which to make confident judgments about SOCE. As they wrote, "There is limited SOGIECE [sexual orientation and gender identity and expression change efforts]-related research—a critical knowledge gap . . . . Rigorous research syntheses to support or refine legislative proposals related to SOCIECE are not available at this time." (Kinitz et al., 2021, p. 3.)

B. Recent studies purporting to show harm contain fatal methodological errors.

32. There have in fact been a number of recent papers attempting to link what the authors broadly label "SOCE" to psychological harms.[1] However, abundant methodological limitations mean that these attempts are unable to establish harm from voluntary counseling relationships, or to change the conclusion reached by the APA in 2009. Two key examples are sufficient to illustrate the problem.

[1] Blosnich et al., 2020; Green et al., 2020; Meanley et al., 2020; Ryan et al., 2018; Salway et al., 2020.

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1. Sample bias

33. Firstly, multiple recent studies fall into the methodological error of improper generalization. These studies are conducted on samples exclusively made up of those who self-identify as LGBT at the time the study subjects are recruited.[2] This, however, excludes two groups whose experiences and results are extremely relevant to the claims made, and are likely to be quite different than those of individuals who self-identify as LGBT.

34. First, recruiting methods or screens that focus on those who self-identify as LGBT exclude those who have never identified themselves in this way. But research suggests a significant subpopulation of sexual minorities (including those who experience opposite-sex attractions) choose not to be defined by those attractions, and so do not identify themselves as LGBT if asked, and are unlikely to be found in the LGBT-identified networks and venues often utilized by researchers for participant recruitment.[3] These individuals tend to be more traditionally religious, more active in their religion, less engaged in same-sex behavior regardless of experienced attractions, and more interested in a child- and family-centered life.

35. This was noted a generation ago by Shidlo and Schroeder (2002), but has seemingly been ignored in the recent studies. Those authors commented ". . . on the basis of the conversion therapy literature and our own empirical research, we have found that conversion therapists and many clients of conversion therapy steadfastly reject the use of *lesbian* and *gay*. Therefore, to have used gay-affirmative words would have been inaccurate and unfaithful to their views." (249)

36. Thus, given the widespread recognition that most individuals who seek counseling to assist in reducing same-sex attractions are motivated by goals,

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[2] For example, Ryan et al., 2018.

[3] Lefevor et al., 2020; Rosik et al., 2021a.

morality, and a conception of self that are shaped by religious conviction,[4] it appears that studies that recruit subjects exclusively within the self-identifying LGBTQ community are thereby excluding from their samples a large number—perhaps a majority—of those who seek out and participate in voluntary counseling with the goal of reducing same-sex attractions or behaviors. There is no reason to believe that the experiences and reactions of the self-identifying LGBTQ subjects whom they have surveyed—even if accurately self-reported—reflect the experiences of a large number of sexual minorities. On the contrary, it would be reasonable to hypothesize that such counseling is likely to be more effective for, and appreciated by, precisely those who do not consider experienced sexual attractions to define who they are.

37. The exclusion of these sexual minorities from the study samples makes any generalization of harm reported in these recent studies to counseling of individuals who do not self-identify as LGBTQ a scientifically improper research practice.

38. In a related but separate biasing effect, recruitment of subjects for non-longitudinal studies from among those who self-identify as LGBT also excludes those who *did* at one time identify in that way, but for whom therapy was sufficiently effective that they *no longer* identify as LGBT, or at least no longer frequent LBGT-identified networks and venues used for recruitment. One scholar has identified and criticized the sample of a recent major study as suffering from

[4] The APA's 2009 task force report noted "most SOCE currently seem directed to those holding conservative religious and political beliefs, and recent research on SOCE includes almost exclusively individuals who have strong religious beliefs." The report further reported that those who seek counseling with a goal of moving away from same-sex attractions are "predominately . . . men who are strongly religious and participate in conservative faiths." (25) Several years later, Professors Diamond and Rosky, after surveying the literature, reached the same conclusion, writing that "majority of individuals seeking to change their sexual orientation report doing so for religious reasons . . . ." Diamond & Rosky, 2016 p. 6.

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this flaw, noting that "those who may have attained the goal of SOCE—to adopt heterosexual identity, orientation or sexual function—were systematically screened from the survey sample, which only included those currently identifying as a sexual minority." Sullins, 2020. In other words, unless this error is avoided, the sample precisely excludes those who are likely to report that therapy was satisfactory, effective, and/or not experienced as harmful.

39. These structural biases in the samples used by such studies are all the more critical given that self-reported, unverified information is itself recognized to present an important risk of distortion and bias. As the 2009 APA Task Force report noted, "People find it difficult to recall and report accurately on feelings, behaviors, and occurrences from long ago and, with the passage of time, will often distort the frequency, intensity, and salience of things they are asked to recall." (29) By utilizing samples whose participants come from diverse religious and socio-political outlooks, not just those who self-identify as LGBTQ, the impact of inaccurate reports distorted by a combination of inaccurate memory and the personal advocacy goals of participants and researchers could be significantly mitigated. Unfortunately, such diverse samples are exceedingly rare in this literature.

2. Failure to conduct before-and-after comparisons

40. Secondly, none of the recent studies that attempt to link "SOCE" to increased distress and suicidality reported and compared against participants' level of distress *prior* to their engaging in "SOCE." That is, these studies report that the study subjects suffered from mental health issues after engaging in "SOCE," but they do not report what level of mental health issues those same subjects suffered *before* engaging in "SOCE."[5] Basic research methodology dictates any study attempting to attribute a cause (e.g., "SOCE") to an effect (e.g., harm) must take

[5] Blosnich et al., 2020; Green et al., 2020; Flentje et al., 2013; Salway et al., 2020.

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into account important and potentially confounding factors. The lack of a control for pre-"SOCE" distress makes it impossible for studies that suffer from this defect to reach any valid conclusions about causation.

41. In one striking example, data that permits an answer to the "before 'SOCE'" question is available but was disregarded in a research paper published by Blosnich et al., 2020. That data negates and even inverts the hypothesis of causation advanced in the published paper. Blosnich et al., utilized a dataset (the Generations survey) available to other scholars. Oddly, Blosnich and colleagues did not take into account data concerning the subjects' pre-"SOCE" distress in their study design even though such information was available in the same dataset, yet nevertheless these authors purported to find that "SOCE" had "insidious associations with suicide risk" and "may compound or create…suicidal ideation and suicide attempts." I will note that "insidious associations" is a rhetorical rather than a scientific statement, while "may compound or create" describes a hypothesis that should be tested, not a scientific finding.

42. More recently, Professor Donald Sullins performed a re-analysis of the original study of Blosnich et al. but took into account the "SOCE" distress levels experienced by the study subjects *before* they participated in what Blosnich designates as "SOCE." (Sullins, 2020 (preprint).) Sullins' reanalysis discovered a very different reality. While the effect of controlling for pre-"SOCE" suicidality was larger for adults than for minors, Sullins reported:

> After controlling for pre-existing conditions, there no longer remained any positive associations of SOCE with suicidality in the Generations data. Far from increasing suicidality, recourse to SOCE generally reduced it. For the most part the observed reduction in suicidality is not small, especially for those who received SOCE treatment as adults. Following SOCE, the odds of suicide ideation were reduced by two-thirds (AOR of .30) for adults and by one-third (AOR of .67) for minors. Suicide attempts were reduced by four-fifths (AOR of .20) for adults following SOCE, though they were not reduced for minors . . . (14)
>
> The reduced propensity to progress to suicide attempts following SOCE therapy after previous suicide morbidity was even greater. When followed by SOCE treatment, suicide ideation was less than a fifth as likely (AOR .18, Table 4) and suicide planning less than a seventh as likely (AOR .13, Table 4) to lead to a suicide attempt. Adults who experienced SOCE intervention following suicidal thoughts or plans were 17-25 times (AOR .06-.04, Table 4) less likely to attempt suicide. Minors undergoing SOCE were no more likely (AOR .43-.52, not significant, Table 4) to attempt suicide after initial thoughts or plans of suicide compared to their peers who did not undergo SOCE. (14-15)

43. Sullins goes on to observe that "On the question of SOCE and suicidality, in fact Blosnich et al. may have stated the case exactly backwards." (15).

44. Finally, Sullins goes on to provide an illustrative analogy:

> "Imagine a study that finds that most persons using anti-depressants also have had depressive symptoms, thereby concluding that persons "exposed" to anti-depressants were much more likely to experience depression, and recommending that anti-depressants therefore be banned. This imagined study would have used the same flawed logic as Blosnich et al.'s study, with invidious consequences for persons suffering from depression." (20)

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45. More scholarly criticism of these and other recent studies that suffer from these profound methodological flaws continues to emerge.[6]

III. Available evidence indicates that voluntary counseling to change sexual orientation can be effective in motivated individuals.

46. It is also frequently asserted—despite the extensive evidence that change in the components of sexual orientation is not only possible but frequent—that counseling to assist an individual toward desired change is never effective. Again, the available science does not support this assertion.

A. The conclusions of the 2009 task force of the American Psychological Association.

47. The 2009 APA Task Force report acknowledged that "There are no studies of adequate scientific rigor to conclude whether or not recent SOCE do or do not work to change a person's sexual orientation." (120) More specifically:

> "We found that nonaversive and recent approaches to SOCE have not been rigorously evaluated. Given the limited amount of methodologically sound research, we cannot draw a conclusion regarding whether recent forms of SOCE are or are not effective." (43)

48. The Task Force report further stated:

> "Former participants in SOCE reported diverse evaluations of their experiences: Some individuals perceived that they had benefited from SOCE, . . . [These] individuals reported that SOCE was helpful—for example, it helped them live in a manner consistent with their faith. Some individuals described finding a sense of community through religious SOCE and valued having others with whom they could identify." (3)

[6] D'Angelo et al., 2021 (critique of Turban et al.'s (2020) study on the effects of gender identity conversion efforts); Kalin, 2020 (critique of Bränström & Pachankis (2019) study on the mental health impacts of 'gender-affirming treatments'); Rosik, 2021 (critique of Ryan et al., (2018) study on the effects of 'SOCE'); Rosik et al., 2021b (critique of the Blosnich et al.(2020) study attributing suicidality to "SOCE").

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B. Available evidence shows that voluntary counseling is effective for some individuals.

49. Authors from a variety of perspectives acknowledge that there is evidence that voluntary counseling is effective for at least some individuals who are highly motivated to change sexual attractions and behaviors.

50. A six-year longitudinal study considering willing participants who were motivated at least in part by religious beliefs and goals concluded that "The attempt to change sexual orientation did not appear to be harmful on average for these participants. The only statistically significant trends that emerged…indicated improving psychological symptoms." (Jones & Yarhouse, 2011, p.424).

51. This longitudinal study found that about half of participants reported progress toward their desired goal, with 23% of study participants reporting substantial reduction in homosexual attraction and substantial increase in heterosexual attraction and functioning, while an additional 30% of participants reported that same-sex attraction remained present only incidentally or in a way that did not seem to bring about distress.

52. A 2010 study surveyed 117 men who participated in some form of secular or religious counseling or support group activities designed to reduce same-sex attraction. Of these, some were single and some were in heterosexual marriages. 88% were motivated at least in part by what they perceived as conflict between their same-sex desires and conduct and the teachings of their faith. Within the whole study group, responses indicated a "large effect" in decrease of same-sex attractions and behavior, and also a "large effect" in increase of heterosexual attraction and behavior. (Karten & Wade, 2010).

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53. Looking at a very different population, well-received studies on voluntary, talk-based therapy pursued with gay and bisexual men with the treatment goal of suppressing or decreasing casual same-sex behavior to reduce HIV transmission risk reported success in decreasing same-sex behavior over an extended period of time.[7] Standard therapies, culturally adapted standard therapy, and lay peer counseling were shown in replicated, randomized, control trials to significantly decrease casual same-sex behavior and maintain gains at 6 to 12 month follow up. The goal behind these studies was to reduce HIV transmission among this population, but the success of these studies contradicts the hypothesis that counseling with a goal of reducing same-sex behavior is necessarily ineffective. In addition, none of these studies reported adverse effects from the counseling on the mental health of the subjects.

I declare under penalty of perjury that the foregoing is true and correct.

Dr. Chrstopher Rosik

4/23/21

Date

Subscribed and sworn to before me
this 23 day of April, 2021.

Notary Public, State of California
My Commission expires 11-01-2024

[7] Nyamathi et al., 2017; Shoptaw et al., 2005; Shoptaw et al., 2008; Reback & Shoptaw, 2014.

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Fresno

Subscribed and sworn to (or affirmed) before me on this 23 day of April, 2021, by Dr. Christopher Rosik,
proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

ESMERALDA GONZALEZ
Notary Public - California
Fresno County
Commission # 2336716
My Comm. Expires Nov 1, 2024

(Seal)

Signature

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Appendix A: Curriculum Vitae

Christopher Hastings Rosik

1734 W. Shaw Avenue
Fresno, California 93711

I. Education.

B. A.	University of Oregon (Honors college), Eugene, Oregon, 1980 (psychology).
M.A.	Fuller Theological Seminary, Pasadena, California, 1984 (theological studies).
Ph.D.	Fuller Graduate School of Psychology, Pasadena, California, 1986 (clinical psychology - APA approved program).

II. Honors.

Phi Beta Kappa, Alpha of Oregon, 1980.
Exemplary Paper in Humility Theology Award, John Templeton Foundation, 1998.

III. Professional Experiences.

9/85 - 8/ 86	Clinical psychology intern, Camarillo State Hospital, Camarillo, California (APA approved internship).
11/86 - 5/88	Postdoctoral intern, Link Care Center, Fresno, California.
5/88 - Present	Licensed clinical psychologist, Link Care Center, Fresno, California.
11/94 - 6/96	Assistant Clinical Director, Link Care Center, Fresno, California.
7/96 - 12/99	Clinical Director, Link Care Center, Fresno, California.
1/01 – Present	Clinical Faculty, Fresno Pacific University
1/05 – Present	Director of Research, Link Care Center, Fresno, California

IV. Professional Affiliations.

1/84 - Present	Member, American Psychological Association.
1/86 - Present	Member, Christian Association for Psychological Studies (CAPS).
6/90 - 6/93	Member, board of directors, CAPS-Western region.
6/01 – 5/05	President-Elect, President, and Past-President, CAPS-Western Region
1/92 - Present	Member, International Society for the Study of Dissociation.
7/99 – Present	Member, Alliance for Therapeutic Choice and Scientific Integrity (Alliance)
1/11 – 12/17	President-Elect, President, and Past President, Alliance
1/11 - Present	Member, National Association of Social Workers.

V. Recent Litigation Engagements.

Vazzo v. City of Tampa, Florida, Expert declaration submitted May 6, 2019, rebuttal declaration submitted July 17, 2019. Expert testimony by deposition. (M.D. Fla. 2019)

VI. Selected Publications.

Rosik, C.H. (1989). The impact of religious orientation on conjugal bereavement among older adults. International Journal of Aging and Human Development, 28, 251-260.

Rosik, C.H. (1992). Multiple personality disorder: An introduction for pastoral counselors. The Journal of Pastoral Care, 46, 291-298.

Rosik, C.H. (1992). On introducing multiple personality disorder to the local church. Journal of Psychology and Christianity, 11, 263-268.

Rosik, C.H. (Ed.) (1993). Counseling Christians in Ministry [Special issue]. Journal of Psychology and Christianity, 12(2).

Rosik, C.H. (1993). Mission-affiliated versus non-affiliated counselors: A brief research report on missionary preferences with implications for member care. Journal of Psychology and Christianity, 12, 159-164.

Ritchey, J.K., & Rosik, C.H. (1993). Clarifying the interplay of developmental and contextual factors in the counseling of missionaries. Journal of Psychology and Christianity, 12, 151-158.

Rosik, C.H. (1995). The misdiagnosis of MPD by Christian counselors: Vulnerabilities and safeguards. Journal of Psychology and Theology, 23, 72-86.

Rosik, C.H. (1995). The impact of religious orientation in conjugal bereavement among older adults. In J. Hendricks (Ed.), The Ties of Later Life (pp. 87-96). New York: Baywood Publishing Company.

Rosik, C.H. (1995). The unification of consciousness: Approaches to the healing of dissociation. Journal of Religion and Health, 34, 233-246.

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